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Supreme Court, U.S.
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No. _____

In the Supreme Court of the United States

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS, WADAYS VERAS, and RUTH AROCHO As Parent and Natural Guardian of Crystal Veras,and Yashora Veras
Petitioners

-vs-

COUNTY OF LEHIGH and DALE MEISEL,
Respondents

On Petition for Writ of Certiorari to
The Supreme Court of Pennsylvania

APPENDIX VOLUME II
(Pages 64-147)

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SECTION 5 - MEDICAL SERVICES

UBJECT: Suicide Prevention

URPOSE: To provide written procedures regarding Lehigh County Prison's suicide prevention program in order to protect inmates from self-harm or death.

PPLICABILITY: This policy applies to staff and inmates at Lehigh County Prison.

OLICY: It is the policy of Lehigh County Prison to provide special housing, increased levels of observation, and medical restraint to those inmates who display self-destructive behavior.

EFERENCES: National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails 1996-J-05, J-10, J-51

ACA-3-ALDF-4E-11
ACA-3-ALDF-4E-12
ACA-3-ALDF-4E-16
ACA-3-ALDF-4E-20
ACA-3-ALDF-4E-32
ACA-3-ALDF-4E-34
ACA-3-ALDF-4E-37
ACA-3-ALDF-4E-38

37 PA Code 95.232

PA Mental Health Act of 1976

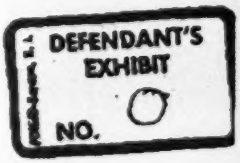
ROCEDURE:

IDENTIFICATION & REFERRALS:

A. As part of the Initial Receiving Screen, Registered or Licensed Practical Nurses shall evaluate all inmates for suicide risk.

B. Any inmate who expresses suicidal ideation or behaviors to a staff member shall be immediately referred to medical staff.

C. The referring staff person shall generate an incident report, and the Shift Commander shall forward a copy to the medical department.



2. ASSESSMENT AND COMMUNICATION:

A. A nurse or psychiatrist will evaluate any inmate who has been identified as a potential suicide risk.

B. If the evaluator concludes that the inmate requires an increased level of care, the disposition may include close observations, suicide precautions or medical restraint.

C. The disposition shall be communicated to the Housing Unit Officer by phone.

D. Medical staff shall complete the Medical Status Form including disposition and level of monitoring required. A copy of the form shall be distributed to the Shift Commander, Treatment Department and Housing Unit Officer.

E. In the case of suicide precautions, the form must be immediately signed by the Shift Commander prior to distribution. The Shift Commander shall forward a copy to the Housing Unit Officer (see attachment #1).

F. The Medical Staff shall enter the disposition in the special needs computer program.

3. MONITORING AND HOUSING:

A. Levels of increased observation and care.

1) Close Observation:

a) Close observation includes a specified time interval for checking an inmate's behavior.

b) Close observation is documented by the Housing Unit Officer on the Psychiatric Check Report and submitted to the Medical Department at the end of each shift.

c) Medical staff will review the check reports each shift for any significant changes in behavio (attachment #2).

2) Suicide Precaution: This involves the inmate in an open-barred cell for direct observation, removing the inmate's clothing and all other cell contents.

a) The Housing Unit Officer shall issue a heavy blanket in good structural condition to the inmate.

b) The Nurse shall place the inmate on Finger Foods/No Utensil status.

c) The Housing Unit Officer shall offer a daily shower to the inmate and directly supervise the inmat showering.

d) The Housing Unit Officer shall monitor the inmate at irregular fifteen-minute intervals (no mo than fifteen minutes between checks). The checks are staggered so that there is no predictabl pattern for the inmate to use in planning suicide.

e) The Housing Unit Officer shall document suicide checks on the psychiatric check form and subm it to the medical department at the end of each shift.

f) Medical staff will review the check report each shift for any significant changes in behavior.

g) Medical staff will have daily contact with the inmate.

h) In the event of an official visitor (i.e. attorney, parole official) the inmate will be dressed ar escorted to the appropriate visit area and remain under direct visual observation by the escortin officer.

3) Medical Restraints: Upon a physician's order, an inmate may be placed in the Restraint Chair (RC) if he or she exhibits extreme behavior potentially or actually harmful to self or others and no other less restrictive treatment is appropriate.

a) The RC is the only approved form of medical restraint.

b) Staff supervising the placing of an inmate into the Restraint Chair must be trained in its use.

c) Medical personnel must check the initial application of restraints to ensure circulation is not impaired.

d) The inmate will be dressed in clothing appropriate to temperature unless otherwise specified by the mental health order.

e) Medical staff shall make an assessment every two hours of the inmate's behavior, position, restraints, and health care needs (food, water, elimination and cleanliness) and ensure the needs are met.

f) The Housing Unit Officer shall monitor the inmate at irregular fifteen-minute intervals (no more than fifteen minutes between checks).

g) The Housing Unit Officer shall document medical restraint checks on a Psychiatric Check Report Form and submit them to the Medical Department at the end of each shift.

h) Medical staff will review the check report each shift for any significant changes in behavior.

i) The Housing Unit Officer shall document each time the inmate is released from medical restraints, or the reason for not releasing the restraints.

j) Medical restraint orders shall not exceed 24 hours.

k) Medical restraints shall not be removed without a physician's order with the following exception. The Housing Unit Officer shall remove the restraints every two hours for ten minutes unless the inmate is extremely agitated. The inmate must be monitored continuously when out of medical restraints.

B. Inmate Monitors

1) Inmate monitors may be assigned at the discretion of the medical staff to assist Correctional Staff in directly observing inmates who are on close observations, suicide precautions and medical restraints.

2) Inmate monitors do not relieve staff from their responsibility to check on the condition of the inmate.

Effective Date April 20, 2001

Edward G. Sweeney, Director

App. 67

STANDARDS FOR HEALTH SERVICES IN JAILS

NATIONAL COMMISSION ON
CORRECTIONAL HEALTH CARE

1996
Second Printing

DEFENDAN
EXHIBIT
NO. M 1

Discussion

An *infirmary* is an area within the confinement facility accommodating two or more inmates for a period of 24 hours or more, expressly set up and operated for the purpose of caring for patients who are not in need of hospitalization or placement in a *licensed nursing care facility*. *Infirmary care* is defined as inpatient bed care by or under the supervision of a registered nurse for an illness or diagnosis that requires limited observation and/or management but does not require admission to a licensed hospital or nursing care facility.

The determination of sufficient and appropriate health care personnel is based on the number of patients, the severity of their illnesses, and the level of care required for each and should be addressed in the staffing plan (see J-23). Being within sight or hearing of a health care staff person means that the inmate-patient readily can gain the person's attention. Call lights and buzzer systems are useful ways of ensuring this.

Advancement of the quality of care in this type of medical area begins with the assignment of responsibility to one physician. Depending upon the size of the infirmary, this physician may be employed part- or full-time.

Nursing care policies and procedures should be consistent with professionally recognized standards of nursing practice and in accordance with the nursing practice act and licensing requirements of the state. Policies and procedures should be developed on the basis of current scientific knowledge and take into account new equipment and current practices.

The inpatient record should include admitting notes, a discharge plan (see J-42 Continuity of Care) including a summary if the patient has been discharged, and complete documentation of the care and treatment given. If the inpatient record is retained separately from the outpatient record, a copy of the discharge summary from the inpatient facility should be placed in the inmate's outpatient chart.

A *licensed nursing care facility* provides long-term or rehabilitative care to patients with chronic physical or mental disabilities.

J-51 Suicide Prevention (essential)

Written policy and defined procedures require, and actual practice demonstrates, that the jail has a program for identifying and responding to suicidal individuals. The program components include identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and *critical incident debriefing*.

Discussion

While inmates may become suicidal at any point during their stay, high-risk periods include the time immediately upon admission to a facility (especially if inmates are intoxicated from alcohol or other drugs); after adjudication, when the inmate is returned to a facility from court; following the receipt of bad news regarding self or family (such as serious illness or the loss of a loved one); and after suffering some type of humiliation or rejection. Individuals who are in the early stages of recovery from severe depression may be at risk as well.

Key components of a suicide prevention program include the following:

1. Identification. The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk (see the sample screening forms and guidelines in Appendix F).

2. Training. All staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide. The plan should include initial and subsequent training.

3. Assessment. This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.

4. Monitoring. The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained. (Refer to sample suicide precaution protocol in Appendix F for further discussion on monitoring.)

5. Housing. A suicidal inmate should not be housed or left alone. An appropriate level of observation must be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the inmate should not be isolated. Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes. An inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility. The room should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself).

6. Referral. The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.

7. Communication. Procedures should exist for communication between health care and correctional personnel regarding the status of the inmate (see J-60).

8. Intervention. The plan should address how to handle a suicide in progress, including appropriate first-aid measures.

9. Notification. Procedures should be in place for notifying jail administrators, outside authorities, and family members of potential, attempted, or completed suicides.

10. Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.

11. Review. The plan should specify the procedures for medical and administrative review if a suicide or a serious suicide attempt (as defined by the suicide plan) does occur.

12. *Critical incident debriefing.* Responding to and/or observing a suicide in progress can be extremely stressful for staff and inmates. The plan should specify the procedures for offering critical incident debriefing to all affected personnel and inmates.

J-52 Intoxication and Withdrawal (essential)

The responsible physician has approved written policy, procedures, and specific protocols for inmates under the influence of alcohol or other drugs or those undergoing withdrawal. Inmates experiencing severe intoxication (overdose) or withdrawal are immediately transferred to a licensed acute care facility. Established guidelines for the treatment and observation of individuals manifesting mild or moderate symptoms of intoxication or withdrawal from alcohol and other drugs are developed and followed. Individuals at risk for progression to more severe levels of intoxication or withdrawal are kept under constant observation by qualified health professionals or health-trained correctional officers. *Medical detoxification* is done only under medical supervision in accordance with local, state, and federal laws.

Discussion

Significant percentages of inmates admitted to correctional institutions have a history of alcohol or other drug abuse. Newly incarcerated individuals may enter intoxicated or develop symptoms of alcohol or other drug withdrawal. Alcohol withdrawal is the abstinence syndrome with the highest mortality rate, although opiate and tranquilizer withdrawal are, on occasion, life-threatening. Barbiturate withdrawal, while rare in

Wexford Health Sources, Inc.
Guidelines and Standards for Correctional Health Care - Jails

Suicide Prevention - Essential

Subject: Suicide Prevention; J-51.00

Purpose: To outline program to effectively address the risk of suicide within the inmate population.

Procedure:

1. Inmates will be evaluated for potential suicide risk at intake, as outlined in Policy 30.00, *Receiving Screening*.
2. Potentially suicidal inmates will be managed as outlined in Policy 51.01, *Management of Potentially Suicidal Inmates*.
3. Administrative review of completed suicides will be as outlined in Policy 10.00, *Procedures in the Event of an Inmate Death*.
4. Training of correctional staff in the identification and management of suicide risk will be as outlined in Policy 19.00, *Training for Correctional Officers*.
5. Since observing a suicide in progress can be extremely stressful for staff and inmates, critical incident debriefing measures will be offered to all responding health care personnel, as well as to observing inmates. The Health Care Unit Administrator shall appoint a health care staff member qualified to refer affected persons to a mental health professional.

References: National Commission on Correctional Health Care: Standards for Health Services in Jails, 1996 J-51
American Correctional Association, Standards for Adult Local Detention Facilities, 3rd Edition, 1991 3-4378-3A

Health Care Unit Administrator — Date: 8/16/01 3/13/02

Medical Director — Date: 8/2/01 3/13/02

Wexford Health Sources, Inc.
Guidelines and Standards for Correctional Health Care - Jails

Management of Potentially Suicidal Inmates

Subject: Suicide Prevention - Management of Potentially Suicidal Inmates; J-S1.01

Purpose: To establish guidelines and procedures to manage suicidal, or potentially suicidal inmates, consistent with security requirements and accepted mental health practices.

Policy: 1. Whenever an inmate demonstrates or reports a risk for self-destructive behavior, immediate assistance will be provided.

2. Precaution procedures will be implemented until evaluation by mental health staff.

3. Mental health evaluation will determine the subsequent actions needed to provide the inmate support and monitoring during critical period.

Procedure: 1. Institutional staff will be trained in the identification of potentially suicidal inmates. Signs of risk for self-destructive behavior include the following:

a. Inmate engages in, or attempts to engage in behavior with potential for self-harm (e.g., swallows razor blades, places plastic bag over head, self-mutilation).

b. Inmate threatens to attempt suicide.

Health Care Unit Administrator — Date 8/16/01 3/6/02

Medical Director — Date 8/24/01 3/13/02

Management of Potentially Suicidal Inmates (Continued)

Procedure:

c. Inmate talks about suicide or self-injurious behavior with staff or other inmate(s).

d. Inmate has a documented history of previous suicide attempt(s) or self-harm.

e. Inmate exhibits markedly sad, tearful behavior, or reduced emotional reactivity.

f. Inmate makes vague references to death.

g. Inmate exhibits dramatic shift from depression to elation, or agitated depression to calm.

h. Inmate appears withdrawn with minimal responding, typically in flat emotionless tone.

l. Inmate informed of significant family crisis (e.g., death of family member, divorce).

j. Inmate has recently been sentenced, or denied release.

k. Inmate has conflicting feelings about impending release.

2. Referral of Potentially Suicidal Inmate

a. Inmate who has attempted suicide will receive immediate medical attention. Once emergency medical treatment is completed, mental health staff will perform evaluation.

b. In all incidents of suicide, or suicidal attempts resulting in hospitalization, the Health Care Unit Administrator will be notified immediately.

c. Any staff member of the institution concerned that an inmate may be potentially suicidal will inform the medical staff immediately.

Management of Potentially Suicidal Inmates (Continued)

Procedure:

d. An inmate identified as potentially suicidal will be evaluated as soon as possible by mental health staff. Pending evaluation, the inmate will be kept under constant observation.

3. Evaluation of Potentially Suicidal Inmate

a. Evaluation by mental health staff will include, but not be limited to the assessment of the following:

1. Inmates mental status
2. Inmates self-report or behavior resulting in referral
3. Current suicidal risk (ideation, plans, lethality of plan, recent stressors, goal or behavior)
4. History of suicidal behavior / ideation, how often, when, method used or contemplated, why, consequences of prior attempts / gestures
5. Inmates report of his/her potential for suicidal behavior

b. Mental health staff will consult with psychiatrist to assist in evaluation if needed.

c. Whenever mental health staff feels unable to make judgment of current suicide potential, the inmate will be managed as potentially suicidal.

4. Disposition

a. If mental health staff determines that suicide threat was issued as a manipulative gesture, inmate presents no evidence of psychological distress, and inmate denies current suicidal ideation / intention, the inmate will be returned to housing unit with recommendation that mental health staff be contacted if needed.

b. If mental health staff determines that inmate is depressed and/or anxious, but not an actual suicide risk, the inmate will be counseled and returned to housing unit. Inmate will be monitored by mental health staff until the presenting symptoms have remitted.

Management of Potentially Suicidal Inmates (Continued)

c. If mental health staff determines that inmate is in danger of immediate or delayed self-harm, the inmate will be place under suicide precautions.

5. Precautions for potentially suicidal inmate.

a. Inmate will be placed in area designated by security to permit close observation. If constant observation cannot be maintained, inmate will be place in area with other inmates, but having restricted access to instruments for self-harm.

b. If a stripped cell is used for close observation, security staff will inspect cell prior to inmate placement to ensure no items available for potential self-harm.

c. Inmate will only be allowed personal property appropriate to level of suicidal potential. If risk of suicide is clear and immediate, inmate will be stripped of all clothing and issued one blanket.

d. Inmate who is engaging in self-injurious behavior after placement in seclusion cell will be considered for transfer to inpatient psychiatric setting.

e. Inmate will be observed at least every shift by the nursing staff. These observations will be documented by completion of Mental Health Observation form.

f. Inmate in suicide precaution status will be evaluated daily by medical staff, or psychiatrist when available. Staff will consider transfer to an inpatient psychiatric setting if suicide potential persists.

References National Commission on Correctional Health Care. Standards for Health Services in Jails, 1996. J-51.
American Correctional Association: Standards for Adult Local Detention Facilities, 3rd Edition, 1991. 3-ALDF-4E-34.

ASSESSMENT OF *AROCHO v. LEHIGH COUNTY, ET. AL.*

Introduction

Detailed below is this writer's assessment of the above captioned case. Such assessment is based upon review of documents supplied to date and identified below. As such, this writer reserves the option of amending and/or enlarging upon this assessment if subsequent documents become available.

By way of background, this writer is a project director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts. A nationally recognized expert in the field of suicide prevention in correctional facilities, this writer has served as project director for the *only* four national U.S. Justice Department-funded studies of jail, prison, and juvenile suicide. Since 1986, this writer has also served as editor and project director for the *Jail Suicide/Mental Health Update* newsletter, a quarterly publication devoted to research, training and prevention that is funded by the U.S. Justice Department. This writer has authored over 60 other publications in the area of suicide prevention in jail, prison, and juvenile facilities. These publications are listed in the curriculum vitae attached as Exhibit 1.

In addition, since 1983, this writer has served as a consultant in providing staff training and program assessment/development services in the area of suicide prevention in correctional facilities to numerous local and state jurisdictions throughout the country. This writer also serves as the suicide prevention consultant to the Special Litigation Section of the U.S. Justice Department's Civil Rights Division in its investigation of conditions of confinement in various correctional facilities; serves as an expert consultant to court systems in the development and monitoring of jail

and juvenile suicide prevention programs; and serves as a consultant to several state departments of correction and state juvenile correctional agencies in the area of suicide prevention. Further, this writer has served as an expert witness/consultant in over 240 litigation cases involving suicide in correctional facilities, and has been qualified as an expert in both federal and state courts throughout the country.

This writer was a recent past recipient of the National Commission on Correctional Health Care's Award of Excellence for outstanding contribution in the field of suicide prevention in correctional facilities. This writer's work has been cited in the suicide prevention sections of various state and national correctional health care standards, and training curricula has been utilized by hundreds of correctional agencies throughout the country.

Finally, as a result of research, technical assistance, and consultant work in the area of suicide prevention in correctional facilities, this writer has reviewed and/or examined over 1,500 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 25 years.

Documents Reviewed

The following documents were reviewed in preparation of this assessment. They include: Complaint in Civil Action; Answer and New Matter; Plaintiffs' Answer to Defendants' New Matter; Defendants' Response to Plaintiffs' First Request for the Production of Documents; Defendants' Answers to Plaintiffs' Expert Interrogatories; Defendants' Response to Plaintiffs' First Set of Interrogatories; various arrest and Lehigh County Prison records of Enrique Veras; various

medical and mental health records of Mr. Veras while he was confined in the Lehigh County Prison incident reports/statements written by various Lehigh County Prison personnel regarding Mr. Veras suicide attempts in the Lehigh County Prison on February 10, February 11, March 30, October 2 October 28 and December 4, 2002, as well as his suicide on December 5, 2002; DVD/videotape recording of Mr. Veras' housing unit during the afternoon of December 5, 2002; lesson plan an class rosters of Lehigh County Prison's suicide prevention training from 1995 thru 2002; inciden reports regarding a prior inmate suicide and prior inmate suicide attempts in the Lehigh Count Prison; various Lehigh County Prison policies, including suicide prevention, inmate monitor health care, and use of force and application of restraints; and deposition transcripts of Dal Albright, John Donate, David Dreisbach, David Eitemiller, Ronald Kiefer, Clifford Knappenberge Robert McFadden, Dale Meisel, Nelson Santiago, Garry Stemz, Edward Sweeney, Alex Thomas MD, Gregory Thomas, John Urban, and Tyrone Wright.

Finally, this writer has relied upon the Commonwealth of Pennsylvania's *Title 37, Chapte 95. County Correctional Institutions*; the American Correctional Association (ACA)'s *Standard for Adult Local Detention Facilities*, Third Edition (1991) and pertinent Supplements; as well as th National Commission on Correctional Health Care (NCCHC)'s *Standards for Health Services i Jails* (1996).

Case Analysis

The Complaint contains several allegations that the Defendants displayed both negligenc and deliberate indifference to Enrique Veras, the proximate result of which was his suicide in th Lehigh County Prison on the afternoon of December 5, 2002. This writer was asked by plaintiff

counsel to examine the Complaint, as well as pertinent documents available in this case to date, and give an opinion as to whether, through policy and practice, the actions and/or inactions by the Defendants were either contrary or inconsistent with both national jail standards and standard correctional practice, and were the proximate causes of Mr. Veras' death.

According to available records, 45-year-old Enrique Versa was first confined in the Lehigh County Prison on February 8, 2002 for various charges, including alleged criminal attempt at kidnapping, unlawful restraint, and aggravated assault. He was assessed as being both mentally ill and suicidal soon after his confinement. During the intake process, Mr. Veras became incoherent and it was determined that he had suffered from an overdose of his psychotropic medication. A razor blade was later found in his clothes. Mr. Veras was placed on suicide precautions with the requirement of observation at 15-minute intervals. Two days later on February 10, he was observed to be bleeding from self-inflicted lacerations on his right wrist. He was provided treatment by nursing staff and remained on suicide precautions with observation at 15-minute intervals. The following day (February 11), Mr. Veras was observed with a noose around his neck and tied to the cell bars. The ligature was removed and he remained on suicide precautions. On March 30, he was again placed on suicide precautions with the requirement of observation at 15-minute intervals for self-injurious behavior. Mr. Veras was released from the Lehigh County Prison on April 2, 2002.

Mr. Veras was again confined in the Lehigh County Prison on October 27, 2002 for charges that included alleged aggravated assault and reckless endangerment. At the scene of arrest, he threatened suicide by placing a knife to his throat. He also appeared depressed ("feeling so bad") and threatened suicide ("can't live anymore") during the intake process. Mr. Veras self-reported a

history of mental illness, psychiatric hospitalization, and psychotropic medication. He also ha observable scars from previous self-inflicted injuries. He was placed on suicide precautions in th reception unit (1D2) with the requirement of observation at 15-minute intervals. Several hours late Mr. Veras began to engage in self-injurious behavior by repeatedly throwing himself on the floo and wall of his cell causing head trauma, and was placed in a restraint chair and receive psychotropic medication. He continued to be observed as "quite tearful and depressed." Mr. Vera was subsequently removed from the restraint chair but remained on suicide precautions with th requirement of observation at 15-minute intervals. The following day (October 28), Mr. Veras wa found hanging from the cell bars by a blanket that he had torn into strips. Although the arrivin nurse declared that "he's gone," Mr. Veras remained conscious and was placed in a restraint cha after continuing to threaten suicide. He was subsequently released from the restraint chair an remained on suicide precautions. On November 4, Mr. Veras was relocated to the mental health uni (1D1) and remained on suicide precautions until November 14. Although Mr. Veras remaine housed in the mental health unit, as a result of his suicidal behavior, as well as assaultive behavior t staff, he was punished by receiving a sanction of disciplinary segregation.

During the evening of December 4, 2002, Mr. Veras was requested to change cells in th mental health unit. He refused, became very agitated and was forcefully removed from the unit an relocated in the segregation unit (3C1) at approximately 8:50pm. Upon placement in hi segregation cell, Mr. Veras remained agitated and began to engage in various forms of self-injurio behavior, including banging his head against the floor, bunk and wall; climbing on the top bunk an purposely falling off to the concrete floor; attempting to flush is head down the toilet; and trying t

hang himself by tying his underwear around his neck and to the towel bar in the cell. He was again placed in a restraint chair.

A few hours later at approximately 12:30 am on December 5, 2002, Mr. Veras was released from the restraint chair and placed on suicide precautions with the requirement of observation at 15-minute intervals. For unexplained reasons, he was reportedly observed at 30-minute intervals during the next several hours. Beginning at approximately 7:30am, the officers' logs reflected observation at exact 15-minute intervals. The last documented observation of Mr. Veras on suicide precautions occurred at 4:00pm on December 5, 2002. At approximately 4:16pm, a correctional officer found Mr. Veras hanging from the cell bars by strip of bed sheet. (According to the videotape recording of the housing unit and the suicide attempt, the last time that an officer was in the housing unit was approximately 3:45pm and that officer did not walk past Mr. Veras' cell. Mr. Veras is seen on the videotape to be tying the sheet to the cell bars at 3:56pm and the sheet is visible from that time forward until he was found hanging 20 minutes later at 4:16pm.) The officer called for back-up personnel and several correctional staff arrived shortly thereafter and assisted in cutting the sheet away from the bars. The cell door was opened and Mr. Veras was placed on the floor. Other correctional personnel arrived in the housing area and stood around the victim. Approximately two minutes later at 4:19pm, medical staff arrived and initiated cardiopulmonary resuscitation. At approximately 4:29pm, emergency medical services personnel arrived and continued life-saving measures. Mr. Veras was then transported to a local hospital and subsequently pronounced dead.

Opinions

Based upon review of the case file materials and above summary, this writer offers the following opinions. *First*, there was overwhelming evidence to show that Enrique Veras was at a continuing high risk for suicide in the Lehigh County Prison, and that continuing high risk was known to the defendants and various personnel. *Second*, the Lehigh County Prison had grossly inadequate policies and practices in the area the suicide prevention (particularly levels of observation and safe housing) that were the proximate causes of Mr. Veras' suicide because it was reasonable to assume that the provision of grossly inadequate supervision for continuing high risk suicidal behavior, as well as placement in a dangerous cell, would ultimately result in his suicide. The basis for these opinions is offered below.

1) **Notice of Continuing High Suicide Risk**

There was overwhelming evidence to show that Enrique Veras was at a continuing high risk for suicide in the Lehigh County Prison, and that continuing high risk was known to the Defendants and various personnel. Prison officials and staff disregarded this obvious high risk by failing to take appropriate steps to ensure Mr. Veras' safety during his periodic confinement in the Lehigh County Prison from February 8 thorough December 5, 2002. Such action (or inaction) was completely unreasonable and lacked common sense.

Mr. Veras' continuing high risk for suicide during his confinement in the Lehigh County Prison was graphically exemplified by the following known facts: 1) he had a history of mental illness, psychiatric hospitalization, and psychotropic medication; 2) he was observed to be depressed, agitated, incoherent, "quite tearful" and crying, and displaying numerous self-inflicted

injuries and scars; 3) he self-reported both depression ("feeling so bad") and suicidal ideation ("can't live anymore"), as well as requested to remain in the restraint chair when feeling the impulse to engage in suicidal behavior; and 4) engaged in self-injurious behavior on a least seven separate occasions (immediately prior to or) during his confinement:

- upon intake on February 8 when it was suspected that he overdosed on psychotropic medication,
- on February 10 when he was observed to be bleeding from lacerations on his right wrist,
- on February 11 when he was observed with a noose around his neck and tied to the cell bars,
- on March 30 when he was observed engaging in self-injurious behavior,
- on October 27 when he repeatedly threw himself on the floor and wall of his cell causing head trauma,
- on October 28 when he was found hanging from the cell bars by a blanket that he had torn into stripe, and
- on December 4, 2002 when he observed banging his head against the floor, bunk and wall; climbing on the top bunk and purposely falling off to the concrete floor; attempting to flush is head down the toilet; and trying to hang himself by tying his underwear around his neck and to the towel bar in the cell.

Despite Enrique Veras' continuing high risk for suicide during his confinement in the Lehigh County Prison, the response from the Defendants and staff was the following: placement on suicide precautions in various unsafe cells with the requirement of observation that did not include constant observation (see below), periodic assessment by contracted medical and mental health staff, psychotropic medication, and periodic placement for a few hours in a restraint chair. These responses were grossly inadequate because Mr. Veras was permitted to continue to engage in self-injury and ultimately committed suicide in the facility

2) **Grossly Inadequate Policies and Practices**

The Lehigh County Prison had grossly inadequate policies and practices in the area of suicide prevention (particularly levels of observation and safe housing) that were the proximate causes of Mr. Veras' suicide. A written suicide prevention policy is a prerequisite for running a correctional facility. The importance of written policy in suicide prevention is clearly stated in the American Correctional Association (ACA)'s *Standards for Adult Local Detention Facilities* (3-ADLF-4E-34): "There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional."[1] In addition, the National Commission on Correctional Health Care (NCCHC)'s *Standards for Health Service in Jails* (J-31) requires each jail to have a written suicide prevention plan that includes the following components: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting and review.[2]

The Lehigh County Prison's suicide prevention policy (No. 5.5, effective April 20, 2001) states that the facility will "provide special, housing, increased levels of observation, and medical restraint to those inmates who display self-destructive behavior." The policy references both ACA and NCCHC standards, and Dale Meisel, warden of the Lehigh County Prison, and Edward Sweeney, director of corrections for Lehigh County, both testified in their respective depositions that the suicide prevention policy was largely based upon ACA and NCCHC standards. Yet

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[1] American Correctional Association (1991), *Standards for Adult Local Detention Facilities* (3rd Edition), Lanham, MD: Author.
[2] National Commission on Correctional Health Care (1996), *Standards for Health Services in Jails* (3rd Edition), Chicago, IL: Author.

although Policy 5.5 includes provisions for identification, assessment/ communication, and observation, it is not consistent with ACA and NCCHC standards and is grossly inadequate.

For example, ACA standard 3-ALDF-3D-08 states that:

> Written policy, procedure, and practice require that all special management inmates are personally observed by a correctional officer at least every 30 minutes on an irregular schedule. Inmates who are violent or mentally disordered or who demonstrate unusual or bizarre behavior receive more frequent observation; *suicidal inmates are under continuous observation* (emphasis added)

In addition, ACA standard 3-ALDF-4E-34 states that:

> There is a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional. All staff with responsibility for inmate supervision are trained in the implementation of the program.
>
> Comment: The program should include specific procedures for intake screening, identification, and supervision of suicide-prone inmates.

Finally, ACA standard 3 ALDF 1D 12 states that all correctional staff are required to have *annual* instruction in suicide prevention ("signs of suicide risk" and suicide precautions").

The Lehigh County Prison's suicide prevention policy is also in violation of NCCHC standards. For example, NCCHC's suicide prevention standard (J-51) requires the following:

> **1) Identification.** The receiving screening form should contain observation and interview items related to the inmate's potential suicide risk.
>
> **2) Training.** All staff members who work with inmates should be trained to recognize verbal and behavioral cues that indicate potential suicide. The plan should include initial and subsequent training.

3) Assessment. This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.

4) Monitoring. The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained.

5) Housing. A suicidal inmate should not be housed or left alone. An appropriate level of observation must be maintained. If a sufficiently large staff is not available that constant supervision can be provided when needed, the inmate should not be isolated. Rather, s/he should be housed with another resident or in a dormitory and checked every 10-15 minutes. *An inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility. The room should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself).* (Emphasis added)

6) Referral. The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.

7) Communication. Procedures should exist for communication between health care and correctional personnel regarding the status of the inmate.

8) Intervention. The plan should address how to handle a suicide in progress, including appropriate first-aid measures.

9) Notification. Procedures should be in place for notifying jail administrators, outside authorities, and family members of potential, attempted, or completed suicides.

10) Reporting. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.

11) Review. The plan should specify the procedures for medical and administrative review if a suicide or a serious suicide attempt (as defined by the suicide plan) does occur.

12) Critical incident debriefing. Responding to and/or observing a suicide in progress can be extremely stressful for staff and inmates. The plan should specify the procedures for offering critical incident debriefing to all affected personnel and inmates.

The Lehigh County Prison's suicide prevention policy provides two levels of observation for suicidal inmates: *suicide precaution* and *close observation*. According to both the policy and deposition testimony in this case, there is little discernable difference between the two supervision levels. In practice, inmates on *suicide precaution* status are stripped naked of their clothing, all items (with the exception of a blanket) are removed from the cell, and they are observed "at irregular 15-minute intervals (no more than 15 minutes between checks). The checks are staggered so that there is no predictable pattern for the inmate to use in planning suicide." Inmates on *close observation* status are allowed to retain their clothing and other possessions and are observed at staggered 15-minute intervals. (It should be noted that, contrary to Lehigh County Prison policy, Mr. Veras was observed for several hours on December 5 at 30-minute intervals, and was rarely observed at staggered or "irregular" 15-minute intervals while on either close observation or suicide precaution status. Instead, the officers' logs were recorded at exact 15-minute intervals.)

Most importantly, according to the suicide prevention policy and deposition testimony of most deponents, both the policy and the practice of the Defendants was not to provide *constant observation* to high risk suicidal inmates (i.e., "*under continuous observation*" per ACA standards or "*on a continuing, uninterrupted basis*" per NCCHC standards) confined within the Lehigh County Prison.

As exemplified in Mr. Veras' case, the placement of an inmate identified as a continuing high risk for suicide on an observation level requiring supervision at 15-minute intervals is grossly inadequate and contrary to national correctional standards and standard correctional practices that

require constant observation and consideration for hospitalization. Observation at 15-minute intervals is routinely reserved for inmates assessed as being either at low or moderate risk for suicide. It defies common sense to expect that observation at 15-minute intervals will successfully thwart the suicide attempts of a highly suicidal individual.

In fact, the Lehigh County Prison was emphatically warned of Mr. Veras' high risk suicidal behavior when, upon his discharge from the emergency room of Sacred Heart Hospital on October 27, 2002, the physician stated: "BE ABSOLUTELY WATCHFUL OF HIS BEHAVIOR CONSIDER THIS PATIENT HIGH RISK FOR REPEATED SELF-INJURY. MUST HAVE SOMEONE WATCHING HIM AT ALL TIMES." A review of all available records in this case indicates that the defendants and their staff never placed Mr. Veras on constant observation nor considered psychiatric hospitalization for his continuing high risk suicidal behavior. Such inaction was unconscionable because it was reasonable to assume that the provision of grossly inadequate supervision for continuing high risk suicidal behavior would ultimately result in his suicide.

Further, the deposition testimony in this case revealed that even the alleged observation of Mr. Veras at 15-minute intervals was not always performed by an officer physically walking past his cell, but rather by an officer stationed inside the control booth which was estimated to be between 30 and 40 feet from Mr. Veras' cell and partially obstructed by the stairway. Alec Thomas, MD, a consulting psychiatrist to the Lehigh County Prison, stated in his deposition (at pages 32-33) that it would be improper for a control booth officer to be responsible for the observation of suicidal inmates, and that he was unaware that such a practice was occurring at the Lehigh County Prison.

As previously stated, the last time that an officer was in Mr. Veras' housing unit on December 5 was at approximately 3:45pm and that officer did not walk past Mr. Veras' cell. Mr. Veras can be seen on the videotape to be tying the sheet to the cell bars at 3:56pm and the sheet is visible from that time forward until he was found hanging 20 minutes later at 4:16pm. It is obvious that none of the officers assigned to the housing unit (including the control officer) adequately observed Mr. Veras prior to his death, the proximate cause of which was his ability to successfully commit suicide. In essence, had the Defendants and their staff followed standard correctional practices and national correctional standards, Mr. Veras would have been observed on constant observation following his most recent high risk self-injurious behavior on December 4 and not had the ability to successfully commit suicide on December 5, 2005.

With regard to housing of suicidal inmates, consistent with national correctional standards and standard practices in correctional facilities throughout the country, housing assignments should be based on the ability to maximize staff interaction with the inmate, avoiding assignments that heighten the depersonalizing aspects of incarceration. Ideally, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. All cells designated to house suicidal inmates should be suicide resistant, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures and ceiling air vents that are protrusion-free. No cell housing a suicidal inmate should have open-faced bars. Rather, each cell door should contain a heavy gauge Lexan (or equivalent grade) glass panel that is large enough to allow staff a full and unobstructed view of the cell interior. Cells housing suicidal inmates should not contain any electrical switches or

outlets, bunks with holes and ladders, towel racks on desks and sinks, radiator vents, corded telephones of any length, clothing hooks (of any kind), or any other object that provides an easy anchoring device for hanging. As reiterated in the NCCHC standards, "The room should be as nearly suicide-proof as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself)."

Although Lehigh County Prison's suicide prevention policy requires "special housing" for suicidal inmates, the policy did not contain any description as to the type of housing provided to such inmates. According to the deposition testimony in this case, suicidal inmates can be placed in a variety of housing units in the Lehigh County Prison. According to the records, none of these placements provided safe housing for suicidal inmates because, at a minimum, they contain open-faced bars, shelves with clothing hooks, metal bunks, and towel racks attached to desks. In Mr. Veras' case, he was placed on suicide precautions in the reception, mental health and segregation units, and he was able to attempt suicide in each of these units. For example, he was found hanging from the cell bars in the reception unit on October 28, tried to hang himself from the towel bar attached to the desk in his cell in the segregation unit on December 4, and successfully committed suicide by hanging himself from the cell bars the following day on December 5. For inexplicable reasons, Mr. Veras was also able to attempt (and commit) suicide with ligatures that were prohibited from being in his cell, including a blanket and sheet.

Given the fact the inmates have historically attempted and/or committed suicide in the Lehigh County Prison utilizing a variety of dangerous anchoring devices (including a successful suicide by hanging of an inmate utilizing a shelf with clothing hooks in July 1995 and a hanging

attempt of a inmate utilizing the open-faced bars in February 2000), it is particularly troubling that Mr. Veras was placed in a cell on suicide precautions that contained protrusions that were obvious and previously known to be dangerous by the Defendants. Also troubling was the fact that Edward Sweeney, I.C.P. Director of Corrections, stated in his deposition (at pages 79-80) that Mr. Veras was placed in a cell that was not safe for housing suicidal inmates and that there were not any suicide-resistant cells in the facility (at pages 82-83). In fact, the Defendants promulgated a suicide prevention policy that required a suicidal inmate to be placed in a dangerous cell (i.e., "Suicide Precaution: This involves the inmate in an open-barred cell"), and Director Sweeney admitted during his deposition that Mr. Veras' cell door "obviously is not suicide-proof in that someone could certainly tie something to the door" (at page 80).

When questioned during their respective depositions regarding why Lexan paneling was not installed on the barred doors of cells housing suicidal inmates, Messrs. Meisel and Sweeney offered similarly inadequate responses, ranging from not having heard of Lexan paneling to the belief that inmates would smear feces on the paneling thus obstructing visibility. Yet heavy gauge Lexan (or equivalent grade) glass paneling is commonly known and utilized in jail and prison facilities throughout the country to cover bars of cells housing suicidal inmates. The Defendants had several options to house suicidal inmates in safe cells, including the placement of heavy gauge Lexan (or equivalent grade) glass paneling on selective cells utilized to house suicidal inmates, housing suicidal inmates in cells that did not have open-barred doors, and ensuring that suicidal inmates were provided with constant observation of a correctional officer who was stationed directly outside the cell. The Defendants chose none of these or other options

and simply continued to allow these obviously dangerous cells to be utilized for housing suicidal inmates.

Finally, this writer has reviewed Lehigh County Prison's 4-hour "In-Custody Suicide Prevention" training lesson plan developed in 1999. Overall, the lesson plan is very good and based in large part on this writer's suicide prevention training curricula. However, a review of the Class Roster revealed that the workshop for in-service suicide prevention training was offered at 1-hour, not 4-hour, durations. In addition, as shown below, contrary to both ACA and NCCHC standards, the Class Roster indicated that the 14 Lehigh County Prison personnel who were deposed in this case either never received suicide prevention training or received it infrequently from 1995 through 2002:

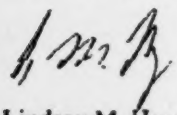
- Dale Albright – no training
- John Donate – no training
- David Dreisbach – received training March 1995 and November 1998
- David Eitemiller – received training May 2001
- Ronald Kiefer – received training September 1998 and April 1999
- Clifford Knappenberger – no training
- Robert McFadden – received training November 1998
- Dale Meisel – no training
- Nelson Santiago – received training May 1997, October 1999 and April 2002
- Garry Stercz – received training October 1996 and October 1999
- Edward Sweency – no training
- Gregory Thomas – no training
- John Urban – received training October 1999
- Tyrone Wright – received training July 1996 and April 1999

Summary and Conclusions

In summary, it would be this writer's opinion that: 1) there was overwhelming evidence to show that Enrique Veras was at a continuing high risk for suicide in the Lehigh County Prison, and that continuing high risk was known to the Defendants and various personnel: 2) despite knowledge that Mr. Veras was a continuing high risk for suicide, the Defendants and various personnel never placed Mr. Veras on constant observation nor considered psychiatric hospitalization; 3) the Defendants had grossly inadequate policies and practices in the area of suicide prevention (particularly levels of observation and safe housing) that were the proximate causes of Mr. Veras' suicide because it was reasonable to assume that the provision of grossly inadequate supervision for continuing high risk suicidal behavior, as well as placement in a dangerous cell, would ultimately result in his suicide; and 4) the Defendants' actions and inactions in not taking adequate precautions to manage Mr. Veras' continuing high risk for suicide reflected both negligence and deliberate indifference to his health and safety.

In conclusion, the suicide of Enrique Veras in the Lehigh County Prison on December 5, 2002 was among a handful of the worst cases that this writer has reviewed during the past 25 years. His death was clearly preventable and the actions/inactions displayed by the Defendants and various personnel can only be described as unconscionable.

Respectfully Submitted By:



Lindsay M. Hayes
October 31, 2005

EXHIBIT 1

VITAE

LINDSAY M. HAYES

PERSONAL INFORMATION

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Mansfield, Massachusetts 02048

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(508) 337-3083 - facsimile
E-Mail: Lhayesta@msn.com

Date of Birth: June 5, 1955

Marital Status: Married, four children

ACADEMIC BACKGROUND

Master of Science – Administration of Justice (1978); The American University, Washington, D.C.

Bachelor of Arts – Sociology (1977); Ithaca College, New York

SUMMARY

Lindsay M. Hayes is a Project Director of the National Center on Institutions and Alternatives, with an office in Mansfield, Massachusetts. He is nationally recognized as an expert in the field of suicide prevention within jails, prisons and juvenile facilities. Mr. Hayes serves as a technical assistance consultant/expert by conducting training seminars and assessing inmate and juvenile suicide prevention practices in various state and local jurisdictions throughout the country.

Mr. Hayes has conducted the only four national studies of jail, prison, and juvenile suicide (*And Darkness Closes In...National Study of Jail Suicides* in 1981, *National Study of Jail Suicides: Seven Years Later* in 1988, *Prison Suicide: An Overview and Guide to Prevention* in 1995, and *Juvenile Suicide in Confinement: A National Survey* in 2004). The jail and prison suicide studies were conducted through contracts with the National Institute of Corrections (NIC), U.S. Justice Department; whereas the first national study of juvenile suicide in confinement was conducted through a contract with the Office of Juvenile Justice and Delinquency Prevention, U.S. Justice Department.

Mr. Hayes has acted as an expert witness/consultant in over 240 suicide litigation cases, as well as appointed to assist special masters in the development and implementation of suicide prevention policies in several adult and juvenile correctional systems under court jurisdiction. He is also a suicide prevention consultant to the U.S. Justice Department's Civil Right Division (Special Litigation Section) in its investigations of conditions of confinement in both adult and juvenile correctional facilities throughout the country.

Mr. Hayes serves as editor/project director of the *Jail Suicide/Mental Health Update*, a quarterly newsletter devoted to research, training, prevention, and litigation that is funded by NIC; and is a consulting editor and editorial board member of *Suicide and Life-Threatening Behavior*, the official scientific journal of the American Association of Suicidology, as well as editorial board member of *Crisis: The Journal of Crisis Intervention and Suicide Prevention*.

the official scientific journal of the International Association of Suicide Prevention. Mr. Hayes has authored over 50 publications in the area of suicide prevention within jail, prison and juvenile facilities, including model training curricula on both adult inmate and juvenile suicide prevention.

As a result of research, technical assistance, and expert witness consultant work in the area of suicide prevention in correctional facilities, Mr. Hayes has reviewed and/or examined over 1,500 cases of suicide in jail, prison, and juvenile facilities throughout the country during the past 24 years. In 2001, Mr. Hayes was presented with the National Commission on Correctional Health Care's Award of Excellence for outstanding contribution in the field of suicide prevention in correctional facilities. His work has been cited in the suicide prevention sections of various state and national correctional health care standards.

IN THE COURT OF COMMON PLEAS OF LEHIGH COUNTY, PENNSYLVANIA
CIVIL DIVISION – LAW

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS and WADAYS VERAS and RUTH AROCHO as Parent and Guardian of CRYSTAL VERAS and YASHERA VERAS	:	**No.: 2003-C-3235**
	:	**JURY TRIAL DEMANDED**
v.	:	
COUNTY OF LEHIGH and DALE MEISEL	:	

NOTICE

YOU HAVE BEEN SUED IN COURT. IF YOU WISH TO DEFEND AGAINST THE CLAIMS SET FORTH IN THE FOLLOWING PAGES, YOU MUST TAKE ACTION WITHIN TWENTY (20) DAYS AFTER THIS PLEADING IS SERVED BY ENTERING A WRITTEN APPEARANCE PERSONALLY OR BY ATTORNEY, AND FILING IN WRITING WITH THE COURT YOUR DEFENSES AND OBJECTIONS TO THE CLAIMS SET FORTH AGAINST YOU. YOU ARE WARNED THAT IF YOU FAIL TO DO SO, THE CASE MAY PROCEED WITHOUT YOU AND A JUDGMENT MAY BE ENTERED AGAINST YOU BY THE COURT WITHOUT FURTHER NOTICE FOR ANY MONEY CLAIMED IN THE COMPLAINT OR FOR OTHER CLAIMS OR RELIEF REQUESTED BY THE PLAINTIFF. YOU MAY LOSE MONEY OR PROPERTY OR OTHER RIGHTS IMPORTANT TO YOU.

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LEHIGH REFERRAL SERVICE
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CIVIL
LEHIGH COUNTY, PA

HAHALIS & KOUNOUPIS, P.C.

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IN THE COURT OF COMMON PLEAS OF LEHIGH COUNTY, PENNSYLVANIA

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS and WADAYS VERAS and RUTH AROCHO as Parent and Guardian of CRYSTAL VERAS and YASHERA VERAS	:	**No.: 2003-C-3235**
	:	**JURY TRIAL DEMANDED**
v.	:	
COUNTY OF LEHIGH and DALE MEISEL	:	

COMPLAINT IN CIVIL ACTION

I. PARTIES

1. Plaintiff Ruth Arocho is an adult female citizen and resident of the Commonwealth of Pennsylvania, and is the duly appointed administrator of the Estate of Enrique Rene Veras, Deceased, and Parent and Natural Guardian of Minor Plaintiffs Crystal Veras and Yashera Veras.
2. Plaintiff Wadays Veras is an adult male citizen and resident of the Commonwealth of Pennsylvania.
3. At all times material hereto, Plaintiffs Wadays Veras, Crystal Veras and Yashera Veras were the children of Ruth Arocho and Enrique Rene Veras, Deceased, and heirs at law of Enrique Rene Veras, Deceased.
4. Defendant, County of Lehigh, maintains its principal office at Lehigh County Government Center, Allentown, Pennsylvania, and maintains operates and administers the Lehigh County Prison, in Allentown, Pennsylvania, and at all times has been a "public entity" under 42 U..S.C. § 12131.

5. Defendant, Dale Meisel (hereinafter "Meisel"), is an adult male citizen and resident of the Commonwealth of Pennsylvania. Meisel is currently serving in his capacity as Warden of the Lehigh County Prison and is responsible for the formulation and/or implementation of practices, policies, and procedures, as well as the day to day operation and overseeing and command and control of certain segments of the Lehigh County Prison, and who at all times relevant hereto was acting within the scope of his duties and authority, under color or title of state or municipal public law or ordinance and supervised or controlled one or more of the other Defendants herein in their conduct or actions, or acted in concert with them in the performance of their conduct or actions.
6. At all times relevant hereto, Defendant County acted by and/or failed to act by and through the conduct of its officers, managers, agents and employees, including but not limited to Meisel, all acting within the scope and course of their employment.
7. At all relevant times herein, Defendants County and Meisel knew, or had reason to know, of the actions and inaction alleged herein and/or has personally participated in some of said actions complained of herein, and are ultimately responsible for same.

II. FACTS

8. On or about December 5, 2002, Plaintiff's Deceased was incarcerated at the Lehigh County Prison.

9. Because of a significant history of mental illness, Plaintiff's Decedent was placed on "suicide watch."

10. Upon information and belief, the policies and practices of Lehigh County as pertain to the Lehigh County Prison provide that prisoners on suicide watch are maintained under constant video surveillance.

11. While Plaintiff's Decedent was on video surveillance by employees, agents and representatives of Defendant County of Lehigh, he fashioned a noose from his bedding, and hanged himself in his cell.

12. Upon information and belief, the policies and practices of the County of Lehigh were the direct and proximate cause of the constitutional harm caused to Plaintiff.

13. As the direct and foreseeable result of the policies and practices of Defendant County, Plaintiff's have been deprived of the support, society and companionship of Plaintiff's Decedent.

14. As the direct and foreseeable result of the policies and practices of Defendant County, Enrique Veras has been deprived of life, liberty and property, all in violation of his rights under the United States Constitution, particularly as guaranteed by the First, Fourth, Fifth and Eighth Amendments thereto.

III. CAUSES OF ACTION

COUNT I
PLAINTIFFS
v.
COUNTY OF LEHIGH AND DALE MEISEL
VIOLATIONS OF 42 U.S.C. § 1983

15. Paragraphs 1 through 14 inclusive, are incorporated by reference as if fully set forth at length herein.

16. The Defendants acted in concert with each other, and all Defendants acted under color of law, and violated the rights of the Plaintiff's Decedent by depriving him of his constitutionally protected right to free speech and to be free from malicious prosecution, false arrest, retaliatory prosecution, and other rights as guaranteed by the First, Fourth, Fifth and Fourteenth Amendments to the United States Constitution, in that Plaintiff's Decedent was subjected to terms and conditions of incarceration in violation of his rights under the First, Fourth, Fifth, Eighth and Fourteenth Amendments.

17. The actions of all the Defendants, collectively and individually in planning, conducting, and carrying out the incarceration of the Plaintiff's Decedent's person and the subsequent actions deprived the Plaintiff of his constitutional rights as guaranteed by the First, Fourth, Fifth, Eighth and Fourteenth Amendments to the Constitution, Section 8 of the Pennsylvania Constitution, and 42 U.S.C. Section 1983 in, *inter alia*, the following manners:

    a. In the unreasonable use of police power and authority, detention and prosecution;

b. In the intentional or negligent infliction of emotional distress upon the Plaintiff's Decedent, designed or calculated to punish the Plaintiff's Decedent;

c. In the development, implementation, and carrying out of a policy, practice or procedure which fails to adequately supervise and secure the person of Plaintiff's Decedent and deprivation of constitutional rights of citizens, such as the Plaintiff's Decedent;

d. In failing to develop, implement and carry out policies prescribing proper conduct of Corrections Officers when surveilling inmates to provide protection to the protected inmates of the Defendant County to be safe and secure in their persons and property;

e. In developing, implementing, and carrying out a policy, practice, or procedure or custom which made no reasonable or proper provision for application of law to provide protection to the inmates of the Defendant County to be safe and secure in their persons and property;

f. In failing to properly train, supervise, monitor and control the actions of all the Defendants so that proper procedures could be accomplished safely;

g. In failing to properly develop, implement and carry out a policy, practice, or procedure or custom which conformed with the Constitutional requirements in arrest, imprisonment, and prosecution of persons such as the Plaintiff's Decedent; and

18. As a direct and proximate result of the a foresaid actions and omissions of all Defendants, the Plaintiff has suffered the following injuries and losses and is entitled to the following damages:

a. loss of the use, benefit and enjoyment of life and personal freedom of movement and association;

b. physical and mental pain and suffering and anguish;

c. loss of valuable and inalienable rights to be free from illegal imprisonment, free from loss of freedom of association;

d. loss of income and future earning capacity;

e. loss of reputation;

f. punitive damages which are justified by the outlandish and outrageous conduct, actions, and omissions of one or more of the Defendants as aforesaid;

g. attorney's fees and costs to defend against the criminal action; and

COUNT II
PLAINTIFFS
v.
COUNTY OF LEHIGH AND DALE MEISEL
WRONGFUL DEATH – 42 Pa.C.S.A. § 8301

19. Paragraphs 1 through 18 inclusive, are incorporated by reference as if fully set forth at length herein.

20. As a direct and proximate result of the negligent and/or intentional actions of Defendants, Plaintiff has suffered the following damages and losses:

a. guidance, tutelage, and moral upbringing;

b. funeral and medical expenses;

c. the total earnings that would have been earned by the Plaintiff's Decedent during his life;

d. the economic value of the Plaintiff's Decedent's life;

e. special expenses provided for in 42 Pa. Cons. Stat. Ann. §

8301(c);

f. Such other damages as are cognizable in law.

COUNT III
ESTATE OF ENRIQUE VERAS
v.
COUNTY OF LEHIGH AND DALE MEISEL
SURVIVAL – 42 Pa.C.S.A. § 8302

21. Paragraphs 1 through 20 inclusive, are incorporated by reference as if fully set forth at length herein.

22. As a direct and proximate result of the negligent and/or intentional actions of Defendants, Plaintiff's Decedent suffered pain, suffering, loss of income, companionship, loss of life's pleasures, and such other damages as are cognizable at law.

V. PRAYER FOR RELIEF

23. Plaintiffs incorporates by reference paragraphs 1 through 22 of their Complaint as though fully set forth at length herein.

WHEREFORE, Plaintiff respectfully requests the Court to:

a. Exercise jurisdiction over their claims;

b. Issue declaratory and injunctive relief declaring the above-described practices to be unlawful, and enjoining their past and continued effects;

c. Award them compensatory damages, including but not limited to reimbursement of all medical and psychological expenses; back pay

and future earnings and loss of earning capacity in the amount of wages and benefits, damages for their mental, psychological and emotional injuries, anguish, humiliation, anxiety, physical and mental pain and suffering and loss of life's pleasures, all of which may be permanent, together with interest, resulting from Defendants' unlawful and tortious conduct;

d. Award them attorneys' fees and costs; and

e. Grant such other relief as the Court deems just and equitable.

JURY DEMAND

Plaintiff demands trial by jury.

Dated: December 8, 2004

HAHALIS & KOUNOUPIS, P.C.

By: _____

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IN THE SUPREME COURT FOR THE COMMONWEALTH OF PENNSYLVANIA

No. _____

RUTH AROCHO, As Administratrix of the ESTATE OF ENRIQUE RENE VERAS, WADAYS VERAS, and RUTH AROCHO As Parent and Natural Guardian of Crystal Veras and Yashera Veras
Petitioners

-vs-

COUNTY OF LEHIGH and DALE MEISEL,
Respondents

PETITION FOR ALLOWANCE OF APPEAL

Petition for Allowance of Appeal from the Order of the Commonwealth Court No. 1008 CD 2006 dated May 3, 2007 Affirming the Order of the Court of Common Pleas of Lehigh County No. 2003-C-3235 dated April 26, 2006 Granting Defendants' Motion for Summary Judgment

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STATEMENT OF THE BASIS FOR THE JURISDICTION

The Pennsylvania Supreme Court has jurisdiction over this Petition for Allowance of Appeal from a final order of the Commonwealth Court pursuant to 42 Pa.C.S. § 724. The Commonwealth Court had jurisdiction over an appeal from the final order of the Court of Common Pleas of Lehigh County, Pennsylvania granting Summary Judgment in favor of Lehigh County and Warden Dale Meisel pursuant to 42 Pa.C.S.A. § 762.

REFERENCE TO REPORT OF OPINIONS BELOW

On April 26, 2006, the Court of Common Pleas, Lehigh County granted Defendants' Motion for Summary Judgment. A copy of the Opinion and Order is attached as Exhibit A. On May 3, 2007, the Commonwealth Court of Pennsylvania affirmed the Court of Common Pleas. A copy of the May 3, 2007 Order and the Opinion of the Commonwealth Court is attached hereto as Exhibit B.

ORDER IN QUESTION

AND NOW, this 3rd day of May, 2007, the Order of the Court of Common Pleas of Lehigh County in the above-captioned matter, entered April 26, 2006, is hereby AFFIRMED.

/s/Mary Hannah Leavitt, Judge

See Appendix B for the Commonwealth Court's Order and Opinion.

QUESTIONS PRESENTED

1. Whether the Commonwealth Court erred in applying the decisions of the United States Supreme Court in *Farmer v. Brennan* and *Collins v. City of Harker Heights* in holding that Lehigh County Could Not be Held Liable for a Constitutionally Infirm Prison Suicide Prevention Policy?

2. Whether the Commonwealth Court erred in holding that Petitioners could not establish an unconstitutional condition of confinement for an inmate at risk of suicide where Plaintiff has proffered an unrebutted expert report that the conditions are constitutionally deficient?

STATEMENT OF THE CASE

The facts surrounding the death of Enrique Veras were stated by the Court of Common Pleas of Lehigh County as follows: [1]

A. MR. VERAS' HISTORY OF SUICIDE ATTEMPTS AT LEHIGH COUNTY PRISON

In February of 2002 Enrique Veras was incarcerated and immediately placed on "suicide precaution" status. On February 11, 2002, Mr. Veras tied a makeshift rope around his neck and tied it to the bars in a suicide attempt. Mr. Veras was returned to "suicide precaution" status on March 30, 2002 and remained on this status until he was released from Lehigh County Prison on April 2, 2002.

Enrique Veras returned to Lehigh County Prison on October 27, 2002, at which time he was placed on "suicide precaution" status. At the time of his arrest on October 27, Enrique Veras threatened to kill himself by placing a knife at his neck. He was seen at Sacred Heart Hospital, resulting in the following recommendation: "BE ABSOLUTELY WATCHFUL

[1] Except as noted with citation, the recitation of the facts are those found by the Court of Common Pleas.

OF HIS BEHAVIOR. CONSIDER THIS PATIENT HIGH RISK FOR REPEATED SELF-INJURY. MUST HAVE SOMEONE WATCHING HIM AT ALL TIMES."[2]

During the intake process at Lehigh County Prison, he expressed depression and threatened suicide. He gave a history of mental illness, psychiatric hospitalization and psychotropic medication. He was placed on suicide precautions in the reception unit (1D2) with the requirement of observation at fifteen minute intervals.[3] While there and under observation, Mr. Veras began throwing himself on the floor and wall of his cell causing head trauma. His was placed in the restraint chair and remained on fifteen minute observation for suicide precautions.[4]

The next day, again while on suicide precautions, Mr. Veras fashioned a noose from bedding, and was found hanging from the cell bars.[5] The nurse that responded opined "he's gone," but in fact Mr. Veras remained conscious and was placed in the restraint chair. After two and a half hours, he

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[2] R.R. v. 1 at p. 75a.
[3] R.R. v. 1 at p. 76a.
[4] *Id.*
[5] R.R. v. 1 at p. 79a

was released from the restraint chair and remained on suicide precautions of fifteen minute observation.[6]

On November 4, 2002, Enrique Veras was transferred to the Mental Health Unit and remained on "suicide precaution" status. Enrique Veras was removed from "suicide precaution" status on November 14, 2002.[7]

Subsequently, on December 4, 2002, Enrique Veras began to engage in self-injurious behavior. Consequently, Enrique Veras was placed in a "suicide precaution cell", specifically Cell 3223 that is located in the Administrative Segregation/Disciplinary Segregation Unit. A Corrections officer in a booth in the pod is responsible for monitoring the inmate on suicide precautions. If the correctional officer in the booth cannot observe the inmate from the control booth, one of the other Corrections Officers on the pod is required to go to the cell in order to check on the inmate.

The policies of the Lehigh County Prison require that a cell to be used as a "suicide precaution cell" must be subject

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[6] *Id.*

[7] Although not found as a fact by the Court, this removal coincided with Mr. Veras being placed in Disciplinary Segregation for destruction of property in connection with his October 28 suicide attempt. R.R. v.1 at p. 80a.

to the best sight line available from the control booth, and be an "open bar" cell. The cells used by Lehigh County Prison as "suicide precaution cells" are supposed to have direct access to the officers and in the visual field of the officers most of the time to make sure that there is nothing that the prisoners can hang themselves with or hang onto.

Immediately upon being placed in the cell in 3C1, Mr. Veras began banging his head on the floor, bunk and wall; throwing himself from the top bunk onto the floor, attempted to flush his head down the toilet, and trying to hang himself by tying his underwear around his neck and to the towel bar in the cell. He was again placed in the restraint chair.[8]

As a result, Enrique Veras was given a blanket and was stripped naked, and upon authorization from the medical department, was placed in a restraint chair between 8:45 P.M. and 9:00 P.M.. Between 10:30 P.M. and 10:45 P.M., correctional officers attempted to remove Enrique Veras from the restraint chair, but Enrique Veras refused to leave the restraint chair, stating that he would harm himself if he were

[8] *Id.*

removed. The medical department placed Enrique Veras on "suicide precaution" status at 11:18 P.M. Enrique Veras was removed from the restraint chair at 12:30 A.M. on December 5, 2002.

On December 5, 2002 at approximately 4:10 P.M. Enrique Veras was found in Cell 3223 standing with his back to the cell door with a ligature around his neck and tied to the cell door. The ligature was characterized as bed linen or a sheet. The correctional officers immediately cut the ligature and summoned medical attention. Enrique Veras was transferred to the hospital where he was pronounced dead at 4:54 P.M.

B. Lehigh County Prison's Suicide Prevention Policy

1. Policy Relating to Monitoring Seriously Suicidal Inmates

Lehigh County Prison has a suicide prevention policy (No. 5.5, effective April 5, 2001) which states that the facility will "provide special housing, increased levels of observation, and medical restraint to those inmates who display self-destructive

behavior."[9] The policy references being based upon standards for suicide prevention policies separately promulgated by the American Correctional Associate (ACA) and the National Commission on Correctional Health Care (NCCHC). The County has never contended that these standards are not applicable to them.

The ACA standards require a provision that mandates constant observation for suicidal inmates.[10] The NCCHC standards require that an inmate assessed as a high suicide risk be observed on a "continuing, uninterrupted basis or be transferred to an appropriate health facility."[11] Corrections Director Edward Sweeney has testified that the Lehigh County Prison suicide prevention policy was based upon those standards.[12]

According to the references section of the LCP policy, a National Corrections Institute Publication was also consulted. That publication,[13] is a report prepared by Lindsay Hayes,

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[9] R.R. v. 1 at p. 59a.
[10] R.R. v. 1 at p. 51a
[11] R.R. v. 1 at p. 57a - 58a; 73a.
[12] R.R. v. 1 at p. 104a.
[13] Excerpted at R.R. at pp. 47a - 58a.

Plaintiff's expert in this case. Director Sweeney reviewed Lindsay Hayes' publications in the process of issuing the LCP Suicide Prevention policy.[14] The recommendations in that report echo the NCCHC requirements for continuous observation of actively suicidal inmates on a one-on-one basis, either by a member of the corrections staff or a fellow inmate.

The LCP policy does not require constant observation of inmates at high risk of suicide, nor does the policy on its face even provide for the possibility of constant observation. Director Sweeney, who issued the policy, had no explanation for why there was no specific provision for constant observation. He stated that there was no reason to omit this classification.[15]

The Corrections Officer in the booth, has a view of the cell in which Mr. Veras was housed (3C1), which is partially obstructed by a staircase.[16]

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[14] R.R. v. 1 at p. 102a.
[15] R.R. v. 1 at p. 105a.
[16] A photograph of the view from the Desk in the Control Booth from which Mr. Veras was supposed to be observed is contained in the record and is reproduced in Appellant's Brief to the Commonwealth Court at p. 10.

2. Policy Relating to Housing Seriously Suicidal Inmates

The NCCHC standard requires that a cell designated for suicide prevention "be as nearly suicide-proof as possible (i.e. without protrusions of any kind that would enable the inmate to hang him/herself."[17] However, the cells used as "suicide prevention" cells at LCP are not suicide resistant in that there are multiple ligature anchor points accessible to the inmate.[18]

The Lehigh County Prison policy provides for only two levels of observation for suicidal inmates: suicide precautions and close observation.[19] The policy does not delineate any real difference between the monitoring of inmates in the two levels, and the deposition testimony of all of the witnesses reveals that the only difference is whether the inmate is maintained clothed or stripped naked.

The suicide prevention cells at LCP all have open face bars, towel bars, and clothing hooks, all of which are potential

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[17] R.R. v. 1 at p. 18a - 21a; 73a.
[18] R.R. v. 1 at p. 116a – 117a.
[19] R.R. v. 1 at p. 60a. The policy also provides for medical restraint (ie. the "restraint chair") as a temporary measure. R.R. at p. 61a.

and easily recognizable ligature anchor points.[20] Director Sweeney has understood that the cells with open faced bars, including the one in which Mr. Veras committed suicide, are not safe for suicidal inmates in that the open bar cells provide multiple ligature points.[21] Director Sweeney stated that an open bar cell is not suicide resistant, since "obviously . . . someone could certainly tie something to the door."[22] Director Sweeney also understood that that there are no suicide resistant cells at the Lehigh County Prison.[23]

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[20] In fact, the Lehigh County Prison policy requires that open bar cells be used for suicide prevention. R.R. v. 1 at p. 125a. The Warden designates what cells are used for suicide prevention. R.R. v. 1 at p. 125a. However, Director Sweeney was the Warden at the time that the suicide cells were designated, and current Warden, Dale Meisel, did not change the designations when he became Warden.

[21] R.R. v. 1 at p. 116a – 117a.

[22] *Id.*

[23] R.R. v. 1 at p. 119a – 120a.

PETITION FOR ALLOWANCE OF APPEAL

The United States Supreme Court has held that a prison official may be liable under 42 U.S.C. § 1983 if he knew that the inmate faced a substantial risk of serious harm and disregarded that risk by failing to take reasonable measures to abate it. *Farmer v. Brennan*, 511 U.S. 825, 847 (1994). In this case, the record is clear that Enrique Veras faced a substantial risk of serious harm from suicide. Lehigh County conceded not only that Mr. Veras had a peculiar risk of suicide, but that the prison officials knew that he did.

Under *Farmer*, the only remaining question was whether Lehigh County Prison failed to take reasonable measures to abate the risk to Mr. Veras. However, rather than follow the clear directions of the United States Supreme Court, both the Court of Common Pleas and the Commonwealth Court embarked upon a parallel enquiry as to whether the general record of suicides and suicide attempts at the Lehigh County Prison put the prison officials on notice of the need for different suicide precautions.

This enquiry was improper because *Farmer* set up two distinct methods of proof as to whether there was a substantial risk of harm from suicide: one enquiry when the prison officials did not have actual notice of a peculiar risk to a particular inmate; and a separate enquiry where the prison officials had recognized that a particular inmate was at risk of suicide. The tests are mutually exclusive. In this case, Lehigh County Prison officials had recognized that Enrique Veras was at imminent risk of suicide, and had placed him on suicide precautions. At the time of his death by suicide, he had been on suicide precautions for approximately eighteen hours. There was no need to further enquire into whether there was a general risk at the prison.

The Commonwealth Court further erred in opining that whether the second part of the *Farmer* test, whether the prison officials took reasonable precautions to abate the known risk of suicide to the inmate, was a question for the Court. The Commonwealth Court cites to *Farmer* for this startling and unprecedented rule, but fails to designate from whence it was drawing this rule. In fact, no such statement is made in

Farmer, and the delegation of the question of whether reasonable steps were taken to the Court is contrary to precedent of the Commonwealth of Pennsylvania and the Federal Courts.

The record supported the conclusion that Lehigh County Prison knew that the provisions that it made for housing suicidal inmates was not proper, and therefore that the precautions were not reasonable. The lower courts erred in deciding the question of reasonableness as a matter of law, and also erred in completely disregarding the uncontested opinion of Plaintiff's expert, Lindsay Hayes, that the LCP procedures were constitutionally infirm.

REASONS SUPPORTING ALLOWANCE OF THE APPEAL

I. The Commonwealth Court Did Not Follow the Controlling Decisions of the United States Supreme Court in *Farmer v. Brennan* and *Collins v. City of Harker Heights*

A. The Commonwealth Court Failed to Properly Apply *Farmer v. Brennan*

The United States Supreme Court has imposed § 1983 liability in a prison suicide case where the prison officials are "deliberately indifferent" to the inmates peculiar vulnerability to suicide. "Deliberate indifference" is a term of art the meaning of which has developed over time. The controlling decision by the United States Supreme Court defines the standard as "a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *Farmer v. Brennan*, 511 U.S. 825, 847 (1994).

The Court in *Farmer* parsed the first requirement into two subparts,

> (1) the detainee had a particular vulnerability to suicide; and
>
> (2) the custodial officer or officers knew of that vulnerability

511 U.S. at 836 ("the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference"). The *Farmer* opinion equates the last factor with a breach of duty. 511 U.S. at 845 ("Whether one puts it in terms of duty or deliberate indifference, prison officials who act reasonably cannot be found liable under the Cruel and Unusual Punishments Clause.")

The Supreme Court explained that the term "deliberate indifference" lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other." *Farmer*, 511 U.S. at 836. It is by this standard – and only this standard – that the Lower Courts were required to consider this case. As demonstrated below, the Lower Courts erred by confusing standards set forth in pre-*Farmer* cases and those applicable in other kinds of § 1983 cases.

1. Knowledge of Vulnerability

In this case, LCP and Warden Meisel conceded for the purposes of their Motion for Summary Judgment that these factors are supported by the record. Even if they had not so conceded, it is undisputed that Enrique Veras had been diagnosed as an immediate suicide risk, and was on Suicide Precautions at the time of his death. Therefore, the standard is met that Enrique Veras had a particular vulnerability to suicide (by virtue of the undisputed diagnosis) and the custodial officers knew of that vulnerability (they maintained him on suicide precautions).

The Lower Courts both placed great emphasis on the lack of a significant history of prior suicides at the Lehigh County Prison. Under *Farmer*, the record of prior suicides and suicide attempts may be relevant to the subjective knowledge enquiry, but only if there was no evidence of subjective knowledge of a particular vulnerability to suicide of the inmate in question.

> Whether a prison official had the requisite knowledge of a substantial risk is a question of fact
>
> * * *
>
> and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious
>
> * * *
>
> [I]f an Eighth Amendment plaintiff presents evidence showing that a substantial risk of inmate attacks was "longstanding, pervasive, well-documented, or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued had been exposed to information concerning the risk and thus 'must have known' about it, then such evidence could be sufficient to permit a trier of fact to find that the defendant-official had actual knowledge of the risk

Farmer, 511 U.S. at 842-43. Since there is no question that the prison and its top officials had actual knowledge of Mr. Veras' particular vulnerability, the prior record (or lack thereof) of suicide attempts is not a proper consideration.

2. Reasonable Measures to Abate the Risk

There is both an objective and a subjective component to a deliberate indifference claim – Did the prison official have

subjective knowledge of a peculiar or general risk; and were the measure taken to abate the risk objectively reasonable. *Farmer*, 511 U.S. at 846 ("to survive summary judgment, he must come forward with evidence from which it can be inferred that the defendant-officials were at the time suit was filed, and are at the time of summary judgment, knowingly and unreasonably disregarding an objectively intolerable risk of harm"); *See also Montgomery v. Pinchak*, 294 F.3rd 492, 499 (3rd Cir. 2002). The only question at issue on Summary Judgment in this case was the second question: whether the Lehigh County Prison failed to take objectively reasonable steps to abate the danger to Enrique Veras. *Farmer*, 511 U.S. at 847 ("a prison official may be held liable under the Eighth Amendment for denying humane conditions of confinement only if he knows that inmates face a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it.")

The Commonwealth Court also erred in requiring proof of *scienter*. Appendix B, p. 8; 2007 Pa. Commw. LEXIS 197, *27. In so holding, the Commonwealth Court mistakenly relied

upon the opinion of the Third Circuit in *Simmons v. City of Philadelphia*, 947 F.2d at 1060-1061. n13. However, the Supreme Court repudiated such a requirement in *Farmer*. The standard of purposeful or knowing conduct is not necessary to satisfy the requirement of deliberate indifference. *Id.* at 836. The Supreme Court further clarified that it did not intend to require a plaintiff to show an intent to harm on the part of the prison, nor did it require direct evidence of the prison's knowledge of the vulnerability. 511 U.S. at 842. Nor must an Eighth Amendment claimant show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm. *Id.* at 842.

B. The Commonwealth Court has Consistently Misapplied *Collins v. City of Harker Heights* As to the Liability of a Municipality for Constitutional Torts Committed by Municipal Actors Who Themselves Have No § 1983 Liability

The Commonwealth Court has linked municipal liability under Section 1983 to proof that a municipal actor is liable for a constitutional tort. In this case, the Commonwealth Court engaged in an extensive analysis of the liability of Warden Meisel, 2007 Pa. Commw. LEXIS 197, *20-32, ultimately holding that Warden Meisel was not liable under § 1983. The Court then disposed of the *Monell* claim against Lehigh County, holding that

> This Court has expressly adopted the *Trigalet* analysis. *Thomas v. City of Philadelphia, 804 A.2d 97, 112 (Pa. Cmwlth. 2002)* ("We hold, therefore, that in the absence of an underlying unconstitutional action by employees of the City . . ., we will not consider the question of whether the City [has liability] . . ."); *Robbins v. Cumberland County Children and Youth Services, 802 A.2d 1239, 1250-1251 (Pa. Cmwlth. 2002)* (accepting the "reasoning of the vast majority of federal circuits, which adopt the general rule that a municipality

> cannot be liable unless there is a constitutional violation by the municipal actor causing the plaintiff's harm").

2007 Pa. Commw. LEXIS 197, *34.

The Court recited the *"Trigalet"* analysis as

> a municipality cannot be held liable in a *Section 1983* action in the absence of a predicate unconstitutional act by the municipality's employee. Even if the municipality's actions are arbitrary or even "conscience shocking, in a constitutional sense" the municipality cannot be held liable under *Section 1983. Id.* [*Trigalet v. City of Tulsa, Oklahoma,* 239 F.3d 1150 (10th Cir. 2001)] *at 1151.* This is because a claim of "inadequate training [or] supervision . . . under *§ 1983* cannot be made out against a supervisory authority absent a finding of a constitutional violation by the person supervised." *Id. at 1154* (quoting *Webber v. Mefford, 43 F.3d 1340, 1344-45 (10th Cir. 1994)).*

2007 Pa. Commw. LEXIS 197, *33-34. This is an accurate statement of the law, as the Third Circuit recognized in *Brown v. Pa. Dep't of Health Emergency Med. Servs. Training Inst.,* 318 F.3rd 473, 482-483 (3rd Cir. 2003). However, a municipality may be held independently liable for a substantive due process violation even in situations where

none of its employees are liable, but have nonetheless violated plaintiff's constitutional rights, *Collins v. City of Harker Heights*, 503 U.S. 115, 122, 117 L. Ed. 2d 261, 112 S. Ct. 1061 (1992) (emphasizing "the separate character of the inquiry into the question of municipal responsibility and the question whether a constitutional violation occurred."). However, "It is not enough that a municipality adopted with deliberate indifference a policy of inadequately training its officers. There must be a "direct causal link" between the policy and a constitutional violation," *Canton v. Harris*, 489 U.S. 378, 385 (1989).

This distinction between municipal liability where no municipal actor has liability under § 1983, and where no municipal actor has violated constitutional rights, is a crucial one, and one which the Commonwealth Court clearly does not understand. A governmental entity is liable under Section 1983 where action pursuant to a municipal policy or custom causes a constitutional tort. *Monell v. Department of Social Services of the City of New York*, 436 U.S. 658, 691 (1978). "[I]t is when execution of a government's policy or custom . . .

inflicts the injury that the government as an entity is responsible under § 1983." *Id.* at 694.

Fourth Amendment claims such as excessive force or arrest without probable cause by police, as in *Canton* and *Monell*, by necessity require action by a municipal employee – a police officer – to bring about the constitutional harm. An Eighth Amendment claim, on the other hand, arises out of taking no action in reliance upon a policy which dictates that no action be taken. The municipal actor (ie. the corrections officers) who are directly involved with the inmate would have no liability for their inaction, because they are acting in accordance with a facially (from the their perspective) valid policy.

The Commonwealth Court mistakenly found that Petitioners based their appeal on *Fagan v. City of Vineland*, 1993 U.S. App. LEXIS 20327 (3rd Cir. 1993), *aff'd* 22 F.3rd 1296 (3rd Cir. 1994)(*en banc*). Recognizing that the *Fagan* decision was roundly criticized, not for its actual holding, but for the implication of that holding, the Commonwealth Court refused to follow *Fagan* in *Robbins*, which held that "a

municipality cannot be liable unless there is a constitutional violation by the municipal actor causing plaintiff's harm." 802 A.2d at 1251. The implication that the Commonwealth Court was rejecting was that there could be municipal liability even if the actions of the municipal actors did not violate the Constitution. Even the Third Circuit has repudiated this in *Brown*.

In *Robbins*, the Commonwealth Court held that a child protective services agency had no duty under § 1983 to protect a child that was not in its custody from private violence, and as there was no breach of any constitutional duty, it was irrelevant whether any municipal policy was improper. The Court never considered whether the County policies were infirm, because the Plaintiff simply failed in its proof that there was any duty owed by the municipal actor.

In *Brown*, the Plaintiff alleged that the City of Philadelphia had a number of policies involving EMTs which were enacted with deliberate indifference and which caused harm to them and their son. Like the Commonwealth Court in *Robbins*, The Third Circuit held that they failed to establish

that the City's policies caused constitutional harm because the City was under no constitutional obligation to provide competent rescue services to Plaintiff from privately-caused harm.

However, there is a clear and established obligation to protect an inmate from a known risk of suicide. Youngberg v. Romeo, 457 U.S. 307 (1982); Estelle v. Gamble, 429 U.S. 97, 103, (1976); Commonwealth, Dep't of Public Welfare, Farview State Hosp. v. Kallinger, 134 Pa. Cmwlth. 415, 423 (Pa. Cmwlth. 1990). The Courts' disagreement with *Fagan* is therefore not pertinent to this case, and proper enquiry can be made into the constitutional adequacy of the Lehigh County Prison Suicide Policy.

As set forth above, the duty in this case has been established, since Mr. Veras had a particular vulnerability to suicide which was recognized by the prison by putting him on suicide precautions. Defendants did not contest, and in fact admitted, and the Court accordingly found that the suicide prevention policy was an official policy enacted by Warden Meisel and ratified by Director Sweeney. The question

remains as to whether those precautions were a reasonable effort to abate the vulnerability to suicide. If not, then the Corrections Officers' actions in compliance with and in furtherance of those policies would be in violation of the Constitution, even if none of them would be liable under the "shocks the conscience" standard. That is the question that remains to be decided by a jury.

II. The Commonwealth Court Erred in Permitting the Question of "Reasonableness" of the Prison Suicide Prevention Policies to be Decided by the Court Rather than By a Factfinder

a. Whether Conduct is Reasonable is a Jury Question

The Commonwealth Court held that the question of whether the Prison's response to the known threat of suicide was a question for the Court, referring without citation to *Farmer*. Appendix B, p. 9; 2007 Pa. Commw. LEXIS 197, *31. ("It is for the courts to determine, under *Farmer*, whether particular conduct is so unreasonable as to constitute the infliction of cruel and unusual punishment.") The Commonwealth Court does not state where in *Farmer* it has

found this pronouncement, and in fact, the Supreme Court has not so delegated this question.

The reasonableness of a particular course of action is the quintessential jury question. *See Boyle v. Pennsylvania R. Co.*, 403 Pa. 614, 616 (Pa. 1961); *Mackowick v. Westinghouse Electric Corporation*, 373 Pa. Super. 434, 541 A.2d 749, 750-51 (Pa. Super. 1988); *Hadar v. Avco Corp.*, 2005 PA Super 326, *12 (Pa. Super. 2005). Appellants identified two major issues relating to whether the County took "reasonable measures to abate the risk." First, the LCP policy does not require, or on its face even provide for, constant uninterrupted observation of inmate on suicide precautions, as set forth in the NCCHC standards, and what observation required is conducted from a place that has inadequate sightlines to permit a proper level of observation from the Control Booth. Second, the suicide cell on 3C1 is dangerous for suicidal inmates in that it provides multiple ligature anchor points on which an inmate may hang himself.

The Lower Courts misinterpreted the decision of the United States Supreme Court in *Bell v. Wolfish*, 441 U.S. 520

(1979) in which the Court held that published standards for prison conditions, while not determinative of constitutional requirements, may be instructive as the accepted standards for prison conditions. 441 U.S. at 543 n. 27. While NCCHC and ACA standards are not binding standards, they are certainly evidence of what are reasonable steps to abate the risk of suicide. *Gates v. Cook*, 376 F.3rd 323 (5th Cir. 2004)(ACA accreditation and compliance with standards are relevant considerations but not dispositive of compliance with the Eighth Amendment (citing *Bell*).

In fact, the LCP suicide prevention policy is based upon both sets of standards, but follows neither. The prison was not able to explain its decision not to follow the standards. This raises a clear question of whether the decision – the product of deliberation – was reasonable. An unreasonable decision which is the product of deliberation is "deliberate indifference." Pembaur v. City of Cincinnati, 475 U.S. 469, 483-84 (1986)("municipal liability under § 1983 attaches where a deliberate choice to follow a course of action is made from among various alternatives by the official or officials

responsible for establishing final policy with respect to the subject matter in question.") The Lower Courts impermissibly intruded into the fact finding function of the jury in determining that the decision to depart from accepted industry standards was reasonable.

b. The Court May Not Make a Decision on Reasonableness As a Matter of Law in the Face of Expert Evidence that the Conduct Was Not Reasonable

Expert testimony is often employed to help jurors understand issues and evidence which is outside of the average juror's normal realm of experience. We have stated that, the employment of testimony of an expert rises from necessity, a necessity born of the fact that the subject matter of the inquiry is one involving special skill and training beyond the ken of the ordinary layman. *Reardon v. Meehan*, 424 Pa. 460, 465, 227 A.2d 667, 670 (1967). Conversely, if all the primary facts can be accurately described to a jury and if the jury is as capable of comprehending and understanding such facts and drawing correct conclusions from them as are

witnesses possessed of special training, experience or observation, then there is no need for the testimony of an expert. *Young v. DOT*, 560 Pa. 373, 376-77, 744 A.2d 1276, 1278 (2000). Although there do not appear to be any reported cases on the question of whether expert testimony is mandatory in a § 1983 case, standards for the incarceration of seriously suicidal inmates are not within the common ken of a layperson, and expert testimony is therefore required.

Normally a plaintiff may establish his case with any evidence, direct or circumstantial. Where, however, the ultimate determinations lie beyond the knowledge or expertise of the average layperson, expert testimony is permitted (and sometimes required) to aid the jury in its understanding of the factors involved and the teaching of the pertinent discipline with respect thereto. *Reardon v. Meehan*, 424 Pa. 460, 227 A.2d 667 (1967); *Weisman v. Sauder Chevrolet Co.*, 402 Pa. 272, 167 A.2d 308 (1961); *Densler v. Metropolitan Edison Co.*, 235 Pa.Super. 585, 345 A.2d 758 (1975); *Hamil v. Bashline*, 481 Pa. 256, 266-267, 392 A.2d 1280 (Pa. 1978)

The question of whether competent and unchallenged expert evidence on a material issue itself precludes Summary Judgment was addressed by this Court in the context of medical negligence in *Hamil.* In that case, the Court noted that

> Whereas typically a plaintiff alleges that a defendant's act or omission set in motion a force which resulted in harm, the theory of the present case is that the defendant's act or omission failed in a duty to protect against harm from another source. To resolve such a claim a fact-finder must consider not only what *did* occur, but also what *might* have occurred, *i.e.*, whether the harm would have resulted from the independent source even if defendant had performed his service in a non-negligent manner

481 Pa. at 270, 392 A.2d at 1287. The Court therefore held that where there is at issue the adequacy of services rendered therefore, a *prima facie* case of liability is established by expert testimony. The Court therefore reversed the award in favor of Defendants.

Similarly, in *Hightower-Warren v. Silk,* 548 Pa. 459; 698 A.2d 52 (1997), this Court held without reliance on *Hamil*, that judgment was improperly entered against Plaintiff, and she

was entitled to a jury trial because the proffered testimony of her expert, when all inferences were drawn her favor, established a *prima facie* case.

One recent reported case suggests that where a Plaintiff has produced relevant and admissible expert evidence, it is error to grant Summary Judgment. In *Morningstar v. Hallett*, 2004 PA Super 337, P16 (Pa. Super. Ct. 2004), the Superior Court reversed the Court of Common Pleas of Franklin County's entry of summary judgment on the issue of whether the grant of summary judgment was in error in denying her the opportunity to present expert evidence and testimony. In that case, the Court of Common Pleas had ruled that the expert evidence in question would not be admitted. The Superior Court overruled both the exclusion and the grant of Summary judgment, holding that there was no support in the record for the exclusion of the proffered testimony, and that since the testimony is directly relevant to the claim Summary Judgment was inappropriate.

There is no principled distinction between a medical negligence case, in which the theory is that the defendant's

omission failed in a duty to protect against harm from another source, and a section 1983 conditions of confinement case, in which the theory is the same. In this case, there has been no consideration of Plaintiff's expert evidence at all. Both the Court of Common Pleas and the Commonwealth Court have simply ignored this evidence. Indeed, Lehigh County has never suggested that Mr. Hayes testimony would not be admissible.

CONCLUSION

The Court of Common Pleas once recognized that this is not a case which is clear and free from doubt as to whether the Lehigh County Prison and Warden Meisel acted reasonably in response to a known risk of serious injury. This was the correct decision. Thereafter, this case took a tortuous route, made even more convoluted by the errors discussed herein. This Petition for Allowance of Appeal requests that this Honorable Court correct the errors of law perpetuated by the Commonwealth Court in the interest of all future inmates who are threatened by suicidal ideation.